STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIVI DING 00		COMPLETED	
			A. BUILDING	06/15/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER		ICHOLAS CT	
CHILLDS	LIOUEE				
SHIELDS	HOUSE		SETIVIC	DUR, IN47274	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R0000					
	This visit was fo	or the Investigation of	R0000	Submission of this response	
	Complaint IN00	_		Plan of Correction is NOT a	- 1
	2			admission that a deficiency	exists
	Compleint INTO	0001420 Substantiated		or, that this Statement of	.,
	•	0091430 - Substantiated.		Deficiencies was correctly c	
		deficiencies related to the		and is also NOT to be const	
	allegations are of	cited at R-297 and R-241.		as an admission against into by the residence, or any	21001
				employees, agents, or other	
	Survey date: 06	5/15/11		individuals who drafted or m	
	,			discussed in the response o	
	Eo oiliter mumah an	:: 004376		of Correction. In addition,	
	Facility number			preparation and submission	of
	Provider number			this Plan of Correction does	NOT
	AIM number:	N/A		constitute an admission or	
				agreement of any kind by th	
	Survey team: S	Sharon Whiteman RN		facility of the truth of any fac	
	j			alleged or the correctness o	f any
	Census bed type	a·		conclusions set forth in this	
				allegation by the survey age	ency.
	Residential: 3				
	Total: 31	l			
	Census payor ty	vpe:			
	Other: 31	_			
	Total: 31				
	101. 31				
	G 1 04				
	Sample: 04				
	This deficiency also reflects state findings				
	in accordance with 410 IAC 16.2.				
	Quality review completed 6/20/11 by Jennie Bartelt, RN.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6V5711

Facility ID:

004376

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 06/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2288 NICHOLAS CT SHIFLDS HOUSE SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE R0241 (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident 's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. R0241 Citation #1 07/22/2011 Based on interview and record review, the R 241 facility failed to insure 1 of 3 residents 410 IAC 16.2-5-4(e) (1) reviewed for medications in a sample of **Health Services** 4, received medications as ordered by physician. (Resident #A) What corrective action(s) will be accomplished for those residents found to have been affected by this Findings include: deficient practice? Resident A no longer resides at Review of Resident #A's closed record on Shields House. 06/15/11 at 11:00 a.m., indicated the How the facility will identify other following: residents having the potential to be affected by the same deficient Resident #A had diagnoses which practice and what corrective included, but were not limited to, action will be taken? The Wellness Director conducted a dementia of Alzheimer's type, depression, review of the Medication and diabetes. Administration Record and the med cart to ensure medication A "Post Discharge to Home Instructions" availability. No other residents were sheet, (not dated) indicated Resident #A found to be affected. was transferred from another facility to What measures will be put into Shields House. The instruction sheet place or what systemic changes listed medications which were sent to will the facility make to ensure Shields House with the resident. The that the deficient practice does not medications included, but were not The licensed nurses and Qualified limited to, (8) Potassium 10 micrograms Medication Aides were re-educated (mcg) (medication supplement used to as to our policy and procedure

004376

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED			
			1	B. WING			06/15/2011	
NAME OF	DROLLIDED OD GLIDDLIE	\		STREET A	DDRESS, CITY, STATE, ZIP CODE	l		
NAME OF PROVIDER OR SUPPLIER				2288 NI	CHOLAS CT			
SHIELDS HOUSE				SEYMO	UR, IN47274			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	1 *	m depletion) tablets to be			concerning documentation and			
	taken twice daily	and (3) Lorazepam			re-ordering of medications for administration as indicated by the	ha		
	(antianxiety med	lication) 1 milligram			physicians order.	iic		
	tablets to be take	en 3 times daily as			physicians craci.			
	needed. The ins	truction's sheet also			How will the corrective action	(s)		
	included an orde	er for Furosemide (a			will be monitored to ensure the			
		ion) 20 milligrams daily.			deficient practice will not recu	r,		
		5 y 1 8 u 2 uu 3 u			i.e., what quality assurance	_		
	Interview of OM	IA #1 on 06/15/11 at 2:20			program will be put into place The Wellness Director and/o			
	1	ne "Post Discharge to			Designee will ensure medica			
	1 ^	•			are ordered and available with			
	Home Instructions" sheet which was sent with Resident #A indicated 8 Potassium				an appropriate time frame so			
					to ensure availability for			
		t with the resident, but			administration. The Wellness			
	1 -	ere actually sent with the			Director will perform a rando			
	resident. QMA	#1 indicated the resident's			weekly review of the medicat cart and resident Medication			
	admission date t	o the facility was			Administration Record for a			
	05/04/11.				period of three months to en	sure		
					continued compliance with			
	Physician's order	rs, dated May 2011,			medication availability. The			
	included an orde	er, dated 05/04/11, which			interdisplinary team will revie			
	indicated Reside	ent #A was to receive 1			findings within three months evaluate the need for the one			
		of Lorazepam at bedtime			monitoring plan. Findings	gonig		
	1	so 1 milligram of			suggestive of compliance wil	I		
	1	nes daily as needed. The			result in cessation of monitor	ing		
	1 *	led another order, dated			plan.			
		· ·						
	05/04/11, which indicated Resident #A was to receive Potassium 10 mcg twice				By what date will the system	nic		
					changes be completed? Compliance Date: 7/22/11			
	daily.				Compliance Date. 1/22/11			
	A Medication Administration form for May 2011 indicated Resident #A received 10 mcg tablets of Potassium on the							
		4/11, and two Potassium						
	1	/11 and 05/07/11.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY  IPLETED  5/2011		
NAME OF PROVIDER OR SUPPLIER SHIELDS HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE  2288 NICHOLAS CT SEYMOUR, IN47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	May 2011 indical Potassium tablet Resident #A on 0 05/10/11, and the The form indicate the facility on the Interview of QM 12:00 p.m., indicate the evening of 0.  The Medication May 2011 indicate a 1 milligram (mon 05/05/11 at 7 7:00 p.m.  Interview of QM 12:00 p.m., indicated the evening of QM 12:00 p.m., indicated the probability of QM #1 indicated was out of Ativated the resident #A recent the evening of QM #1 indicated was out of Ativated the resident	Administration form for ated Resident #A received ag) tablet of Lorazepam (200 p.m. and 05/07/11 at Eated she was certain eived the third dose of ably wasn't documented. The eated she was a mix ident having received her alled, but there was a mix ident having received her are previous facility and ed anymore Potassium or					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COMPLETED			(3) DATE SURVEY	
AND I LAN OF CORRECTION IDENTIFICATION NONIBER.		A. BUILDING 06/15/2011				
			B. WING	ET ADDRESS CITY OF		00/10/2011
NAME OF I	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STA B NICHOLAS CT	ALE, ZIP CODE	
SHIELDS HOUSE				MOUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCE	IVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	COMPLETION DATE
IAU			IAG		. remiter)	DATE
	`	at #A) asked for another re no more Lorazepam				
	1 *	after 05/07/11." QMA #1				
		ew the pharmacy was				
		nes regarding Resident				
		•				
	#A not naving P(	otassium and Lorazepam.				
	The facility faile	d to provide				
	l -	f the pharmacy being				
		Resident #A needing				
	Lorazepam and F					
	Lorazepani and i	otassium.				
	A "Resident Services Notes" form, dated					
		p.m., indicated, "Spoke				
		#A's family) about				
	' ' '	on to return to (previous				
	facility)."	in to return to (previous				
	iacinty).					
	This state resider	ntial tag is related to				
	Complaint IN000	_				
	Complaint if toot	371130.				
D0207	(c) If the facility on	ntrols, handles, and				
R0297	l ' '	ations for a resident, the		1		
		e following for that resident:		1		
		ments to ensure that				
	l ·	ervices are available to				
	l ·	with prescribed medications applicable laws of Indiana.				
	accordance with	applicable laws of findialia.				

004376

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 06/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2288 NICHOLAS CT SHIFLDS HOUSE SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on interview and record review, the R0297 Citation #2 R 297 410 IAC 07/22/2011 16.2-5-6 (c) (1) Pharmaceutical facility failed to insure 1 of 3 residents **Services What corrective** reviewed for medications in a sample of action(s) will be accomplished 4, had medications available from the for those residents found to pharmacy for administration as have been affected by this prescribed. (Resident #A) deficient practice? Resident A no longer resides at Shields House. How the facility will Findings include: identify other residents having the potential to be affected by Review of Resident #A's closed record on the same deficient practice and 06/15/11 at 11:00 a.m.' indicated the what corrective action will be taken? The Wellness Director following: conducted a review of the Medication Administration Record Resident #A had diagnoses which and the med cart to ensure included, but were not limited to, medication availability. No other residents were found to be dementia of Alzheimer's type, depression, affected. What measures will be and diabetes. put into place or what systemic changes will the facility make A "Post Discharge to Home Instructions" to ensure that the deficient sheet, (not dated) indicated Resident #A practice does not recur? The licensed nurses and Qualified was transferred from another facility to Medication Aides were Shields House. The instruction sheet re-educated as to our policy and listed medications which were sent to procedure concerning Shields House with the resident. The documentation and making the necessary provisions to ensure medications included, but were not medications for available for limited to, (8) Potassium 10 micrograms administration as indicated by the (mcg) (medication supplement used to physicians order. How will the prevent Potassium depletion) tablets to be corrective action(s) will be monitored to ensure the taken twice daily and (3) Lorazepam deficient practice will not recur. (antianxiety medication) 1 milligram i.e., what quality assurance tablets to be taken 3 times daily as program will be put into place? needed. The Wellness Director and/or Designee will ensure medications are ordered and available within Interview of QMA #1 on 06/15/11 at 2:20

004376

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
			A. BUILDING B. WING  06/15/2011			011	
			_	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		I		CHOLAS CT		
SHIELDS HOUSE					UR, IN47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	G		DATE	
	1 ^	e "Post Discharge to			an appropriate time frame so to ensure availability for		
	Home Instruction	ns" sheet which was sent			administration. The Wellness		
	with Resident #A	A indicated 8 Potassium			Director will perform a randor	l l	
	tablets were sent	with the resident, but			weekly review of the medicat		
	only 7 tablets we	ere actually sent with the			cart and resident Medication		
	*	‡1 indicated the resident's			Administration Record for a		
	admission date to				period of three months to ens	sure	
	05/04/11.	5 the facility was			continued compliance with		
	US/U <del>T</del> /11.				medication availability. The interdisplinary team will revie	,, l	
		1 1 1 1 1 1 2 2 2 2 2			findings within three months		
	1 * *	der, dated May 2011,			evaluate the need for the ong		
		r, dated 05/04/11, which			monitoring plan. Findings	,	
	indicated Resider	nt #A was to receive 1			suggestive of compliance will		
	milligram tablet	of Lorazepam at bedtime			result in cessation of monitor	ing	
	as needed and als	so 1 milligram of			plan. By what date will the		
	Lorazepam 3 tim	ies daily as needed. The			systemic changes be		
		ed another order, dated			<b>completed?</b> Compliance Dat 7/22/11	:e:	
		indicated Resident #A			1122/11		
	· ·	otassium 10 mcg twice					
		otassium to meg twice					
	daily.						
		lministration form for					
	May 2011 indica	ted Resident #A received					
	10 mcg tablets of	f Potassium on the					
	evening of 05/04	/11, and two Potassium					
	tablets on 05/06/	-					
	A "Nurse's Media	cation Notes" form for					
	May 2011 indicated there were no Potassium tablets available to give Resident #A on 05/08/11, 05/09/11, and						
		morning of 05/11/11.					
	The form indicated the resident had left						
	the facility on the	e evening of 05/11/11.					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION  00	ì í	ESURVEY LETED 2011	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CO		
SHIELDS HOUSE			SEYMO	OUR, IN47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE
	12:00 p.m. indic	IA #1 on 05/15/11 at ated Resident #A had left urn to another facility on 5/11/11.				
	May 2011 indica a 1 milligram (m	Administration form for ated Resident #A received ag) tablet of Lorazepam and 05/07/11 at				
	on 05/05/11 at 7:00 p.m. and 05/07/11 at 7:00 p.m.  Interview of QMA #1 on 06/15/11 at 12:00 p.m. indicated she was certain Resident #A received the third dose of Ativan but probably it wasn't documented. QMA #1 indicated she knew the resident was out of Ativan and Potassium and the pharmacy was called, but there was a mix up due to the resident having received her medications at the previous facility and she never received anymore Potassium or Lorazepam after the 05/07/11 administration of the medications. QMA #1 indicated, "I know I gave her the last Lorazepam on Saturday (May 7, 2011) and she (Resident #A) asked for another pill but there were no more Lorazepam tablets available after 05/07/11." QMA #1 indicated she knew the pharmacy was called several times regarding Resident #A not having Potassium and Lorazepam.					
	The facility faile	•				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC  A. BUILDING  B. WING	00		E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER SHIELDS HOUSE			2288 N	ADDRESS, CITY, STATE, ZIP C ICHOLAS CT DUR, IN47274	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	called regarding Lorazepam and	Resident #A needing Potassium.				
	05/10/11 at 1:00 (with) (Resident resident's decision facility).	vices Notes" form, dated p.m., indicated, "Spoke #A's family) about on to return to (previous ntial tag is related to 091430.				